# Review of the Implementation of the Nurse Prescribing Role

*On behalf of the Trust Nurses Association in Northern Ireland*

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NIPEC

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* Copies of Appendices Five, Six and Seven can be downloaded from the NIPEC web-site www.nipec.n-i.nhs.uk/nurseprescribing.htm

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# EXECUTIVE SUMMARY

1.1 For many years attention has been focused on enhancing the experience of patients and clients using the health service in the UK for many years. This has seen the introduction of new roles and the enhancement of current roles of nurses and midwives, underpinned by the acquisition of new knowledge and the development of new skills and competencies. One such area has been the introduction of nurse prescribing in Northern Ireland, which has had mixed history of success. Anecdotal evidence would suggest that a number of registrants completing programmes are, for a variety of reasons, not practising as nurse prescribers on completion of preparation programmes.

1.2 The Trust Nurses Association (TNA), an organisation which comprises all the Directors of Nursing working in the former Health and Social Services (HSS) Trusts in Northern Ireland, asked NIPEC to consider an evaluation of the prescribing role for nurses and midwives in Northern Ireland. A Scoping Workshop was held to agree the parameters for the project. It was agreed that NIPEC would confine the project to reviewing the implementation of nurse prescribing in Northern Ireland, based on the NIPEC *Development Framework Role Development Guide*, which sets out a structured process for the implementation of new roles. The overall aim of the project was agreed as a review of the implementation of nurse prescribing in Northern Ireland to identify enablers and barriers.

1.3 The implementation of community nurse prescribing in Northern Ireland commenced in 1998 following the publication of the Cumberlege Report (DOH, 1986) and the Crown Report (DOH, 1989). All programmes must meet the requirements of the regulatory body, at that time the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).

1.4 A review of the prescribing, supply and administration of medicines was set up by the Government in 1997. Chaired by Dr June Crown, its findings were published by the Department of Health in 1999, recommending the extension of prescribing by nurses and pharmacists. In 2003, legislation was introduced in Northern Ireland for Extended Independent Nurse Prescribing and

Supplementary [1] Prescribing by nurses and pharmacists [2]. Extended independent and supplementary nurse (and midwife) prescribing in Northern Ireland were first introduced in 2003. A programme was developed for joint provision by the University of Ulster and Queen's University, Belfast, in 2003 to meet the requirements of the regulatory body, the Nursing and Midwifery Council (NMC).

1.5 A Steering Group, chaired by Hazel Baird, Director of Nursing for Homefirst Community HSS Trust, was convened to oversee the work of the project. The group met every two months between October 2006 and May 2007 to receive reports on the progress of the project and to recommend relevant actions.

1.6 The methodology for the project consisted of: questionnaire distribution with lead prescribers[3] and a sample of nurse prescribers; focus group meetings with lead prescribers, prescribing advisers and a sample of nurse prescribers; and, a key stakeholder workshop. The data analysis revealed a number of key themes, which address a range of issues related to the initial introduction and ongoing implementation of nurse prescribing. It could also be argued that these have resonance with the introduction of any role changes for nurses and midwives, both for organisations and for individual practitioners who are taking up a role that is new to an organisation, or whose role is changing substantively. The key themes that emerged included:

- the process of planning for role development
- the nature of the role
- support for the role development
- effectiveness of the role development
- enablers and barriers to the role development.

1.7 The main findings indicate that planning in advance of the development of nurse prescribing was limited, as was the establishment of the necessary

[1] Initially identified as dependent prescribing
[2] HPSS (Amendment relating to prescribing by Nurses, Pharmacists) Regulations (NI) 2003
[3] This term has been used throughout the Executive Summary to identify senior nurses occupying HPSS Trust roles that require them to co-ordinate nurse prescribing activities.

infrastructure to underpin the implementation and support for nurse prescribers themselves. The systems in place to ensure the on-going assessment of their competence and the necessary continuing professional development are also not clearly established in a number of Trusts. In addition, mechanisms to evaluate the effectiveness of the implementation of nurse prescribing have not yet been developed.

1.8 There was, however, recognition of areas of good practice and acknowledgement that robust governance systems are in place to ensure effective risk management. Notwithstanding the areas that are working well and those issues that have been addressed, there are a number of recommendations arising from this evaluation that require consideration. Some of these are specific to nurse prescribing and some are for consideration by Trusts as they continue to develop new roles and extend the roles of nurses and midwives to meet the imperatives of the rapidly changing health services.

1.9 A number of recommendations have been made relating to the implementation of new roles and to the ongoing development of nurse prescribing.

**Recommendation one**

**It is recommended that the DHSSPS, service commissioners and individual Trusts work together to ensure organisational readiness for the implementation of new roles.**

The data collection supports the fact that nurse prescribing was introduced initially due to the driving forces of the Government and the DHSSPS, and that HPSS Trusts responded by adopting a structured approach to the implementation of nurse prescribing. In particular, clear implementation processes were not evident, such as a time frame that would ensure successful introduction of nurse prescribing and the development of the necessary supporting infrastructures. Consideration should be given to the use of the *Development Framework Role Development Guide* as a tool to assist a structured approach to role development.

A significant number of barriers presented themselves during the implementation of nurse prescribing. These caused difficulties to organisations and individual practitioners and prevented nurse prescribing practice achieving its full potential for patients and for service modernisation. It is necessary to ensure that such barriers are identified and action plans developed prior to the implementation of new roles, to ensure that false and real barriers do not impede success.

**Recommendation two**

**It is recommended that policy makers, service commissioners and service providers give consideration to the policies and structures that need to be in place for the introduction of new roles resulting from government drivers.**

There was ample evidence to indicate that issues such as funding, prescription management and electronic communication systems had not been supported by policy development, resulting in barriers and difficulties. It is considered that the introduction of major policy initiatives, such as nurse prescribing, require high level discussion and policy development to ensure successful implementation.

**Recommendation three**

**It is recommended that Executive Nurse Directors, in partnership with Departmental Nursing Advisory Groups and other key stakeholders, should develop a regional strategy to evaluate the effectiveness of new roles introduced through regional policy directives.**

It was evident in the data that there was no structured approach to evaluation of the effectiveness of nurse prescribing, both locally within Trusts and at a regional level. The implementation of new roles should have concurrent development of an evaluation strategy that includes short, medium and long-term activities. The strategy should include the development of mechanisms to evaluate the ongoing implementation of the new role and the overall effectiveness of the role development once the role has been fully embedded.

It is essential that tools are designed to capture data from the time of introduction of the new role. It would be helpful for major policy initiatives such as nurse prescribing to use a regional approach to the development of an evaluation strategy.

Areas that could be included in the evaluation strategy are: organisational readiness; quality and relevance; ongoing competence; prescribing practices; enhancement to patient and client experience; outcomes of care, i.e. quality and effectiveness; patient and client satisfaction. Some of the data can be gathered from the time of implementation of the role, others only when the role has become embedded in practice.

**Recommendation four**

**It is recommended that the necessary information technology support is fully explored, in advance of new roles being implemented and in collaboration with the regional ICT programme board; and that urgent action is taken to address the specific issues arising in relation to nurse prescribing.**

It was evident from the data collected that the information technology infrastructure necessary to support nurse prescribing was still not in place, three years after implementation of nurse prescribing. This included the facility to electronically update patients' drug records and to look up their drug history and allergy status prior to prescribing. Nurse prescribers do not have access to software packages to support prescribing practice such as those available to medical prescribers in primary care. These issues represent a risk to patient safety and need to be urgently addressed.

**Recommendation five**

**It is recommended to health care providers that the implementation of nurse prescribing is supported by job descriptions, KSF outlines, and annual appraisal systems that incorporate nurse prescribing competencies.**

It was evident from the data analysis that there was a need to define clearly the nurse prescribing aspect of the role for those nurses and midwives in posts that require nurse prescribing competence. In addition, appraisal processes did not always address ongoing competence for nurse prescribing. Although it is not necessary to have specific systems related to nurse prescribing, it is necessary to address accountability issues for the nurse prescriber. Peer assessment and supervision should also be explored as a means to enable prescribers to avail of all opportunities to maintain their skills base and sharpen their critical thinking skills.

**Recommendation six**

**It is recommended that the new Health and Social Care Authority (HSCA) should ensure continuance of the current Prescribing Adviser capacity in the four Health and Social Services Boards**

It was acknowledged that each Health Board had appointed a Non-medical Prescribing Adviser and that each Trust had allocated a senior nurse as the lead prescriber, this was commended. It is considered essential that the new HSCA continues with the appointment of Prescribing Advisers to ensure the ongoing development and probity of non-medical prescribing, including nurse prescribing.

**Recommendation seven**

**It is recommended that the each new Health and Social Care Trust makes provision for nurse prescribing co-ordinator roles, with the responsibilities clearly defined in job descriptions and dedicated time provided.**

It was recognised that the nurse prescribing co-ordinators undertook their duties in addition to an already busy work schedule. The data analysis indicated that the lead prescribers did not always have the time required to ensure that governance issues were addressed and to provide the necessary support to nurse prescribers. The reconfiguration of the new HSC Trusts could be the opportunity for exploring this recommendation.

# THE FINAL REPORT

# SECTION ONE

## Introduction

1.1 For many years attention has been focused on enhancing the experience of patients and clients using the health service in the UK for many years. This has seen the introduction of new roles and the enhancement of current roles of Nurses and midwives, underpinned by the acquisition of new knowledge and development of new skills and competencies. The Wanless Review (2002), which was set up to consider the long-term resource requirements of the UK, indicated there was a need to make best use of the resources available within the Health Service, which means that all health service professionals need to consider and embrace new ways of working.

1.2 One such area has been the introduction of nurse prescribing. This has a mixed history of success in Northern Ireland. Anecdotal evidence would suggest that a number of registrants completing programmes are, for a variety of reasons, not practising as nurse prescribers on completion of preparation programmes.

### The Trust Nurses Association

1.3 The Trust Nurses Association (TNA) is an organisation that comprises all the Directors of Nursing working in the Health and Social Services (HSS) Trusts in Northern Ireland. NIPEC's Chief Executive and Officers met with them to discuss work that the two bodies could take forward in collaboration. One of the areas that the TNA asked NIPEC to consider was evaluation of the prescribing role for nurses and midwives in Northern Ireland. NIPEC having given this request its fullest consideration commenced this project in October 2006, with a focus on evaluating the implementation of nurse prescribing in Northern Ireland.

# SECTION TWO

## Community Nurse Prescribing

2.1 The implementation of nurse prescribing in Northern Ireland commenced in 1998, following the publication of the Cumberlege Report (DOH, 1986), which recommended that community nurses should be able to prescribe from a limited number of items, thus enhancing patient care by providing increased access to services. The Crown Report (DOH, 1989) endorsed this and recommended the areas to which nurse prescribing should apply. Nurse prescribing was implemented for district nurses and health visitors in Northern Ireland in 1998 through five pilot sites and a phased roll-out commenced in 1999, with the aim of full implementation being achieved by December 2001. From the autumn of 1999 in Northern Ireland, preparation of district nurses and health visitors was incorporated into all programmes, with stand-alone programmes being provided for those in substantive posts. All programmes had to meet the requirements of the regulatory body, at that time the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC). The Department of Health and Social Services and Public Safety published *Nurse Prescribing: Guidance for Implementation* in October 2000 (replacing draft guidance published in January 1998).

### Extended Independent and Supplementary Nurse Prescribing

2.2 A review of the prescribing, supply and administration of medicines was set up by the Government in 1997. Chaired by Dr June Crown, its findings were published in 1999 (DOH, 1999), recommending the extension of the parameters for prescribing by nurses and pharmacists. In 2003, extended independent and supplementary prescribing was introduced in Northern Ireland for nurses and midwives following publication of the necessary legislation. Nurse and midwife prescribers at that time worked within a limited formulary, covering the areas of practice involving minor injuries, minor ailments, health promotion and palliative care. Supplementary prescribers were able to prescribe within the legislative parameters of across the entire formulary. The DHSSPS published guidance for extended independent and supplementary prescribing (2004a and 2004b).

*Best Practice Guidance for Supplementary Prescribing* was also published by the DHSSPS (2006a).

2.3 It was decided in Northern Ireland that programmes should be developed for nurse and midwife prescribers, to include both extended independent and supplementary prescribing. A programme was developed for joint provision by the University of Ulster and Queen's University, Belfast, to meet the requirements of the regulatory body, the Nursing and Midwifery Council (NMC), which commenced in 2003. The programme is currently under review for re-approval by NMC to meet its new requirements (NMC, 2006).

2.4 Following the initial introduction of prescribing for nurses and pharmacists, the Government introduced legislation to permit independent prescribers in the UK and Northern Ireland (both nurses and pharmacists) to prescribe across the entire formulary, including a limited use of controlled drugs. The DHSSPS has now published additional guidance in this regard, entitled *Improving Patients* Access to Medicines (2006b).

# SECTION THREE

## Review of the Literature

3.1 Exploration of the literature shows that there is limited evidence related to the evaluation of nurse prescribing. The literature available is mostly concerned with nurse prescribing for district nurses and health visitors since it has been in existence for longer. A few studies are now emerging, which relate to independent and supplementary prescribing.

3.2 It is evident that implementation of nurse prescribing for district nurses and health visitors is generally viewed as positive and has had some success (Latter and Courtenay, 2004). What has also been shown is that a number of registrants completing the programme do not practise as nurse prescribers, or have difficulties in implementing their role (Luker et al, 1998; While and Biggs, 2004; Davis, 2005; Fisher, 2004). Hall et al (2003), reporting on factors that community nurse prescribers consider when prescribing, identified that lack of sufficient time to undertake patient assessment and education could be seen as

a barrier to prescribing. In addition, they identified that the nurses in the study were happier to prescribe medications they considered to be low-risk than those they considered to be high-risk, unless the patient's condition had been diagnosed.

3.3 Luker and McHugh (2002) identified that around one quarter of the nurses in their study of community nurse prescribing were not prescribing. Hall et al (2006) undertook a study to investigate why trained community nurses did not prescribe, and identified barriers that prevented them from prescribing or made it more difficult. These included issues such as documentation difficulties, Primary Care Trust boundaries, lack of confidence, limited formulary and part-time working. They also found out that the number of health visitors not prescribing was double that of the district nurses in the study.

3.4 There is limited literature relating to independent and supplementary prescribing. Kimmer and Christian (2005), two extended independent nurse prescribers, undertook a review of their general practice to monitor the usefulness and appropriateness of their nurse prescribing practice. They found that nurse prescribing was useful and effective in relation to their own client group but concluded that the limitations in the formulary were a significant barrier to making full use of their competences and improving their patients' experience. Clegg et al (2006) describe reflections by nurse practitioners who have been prepared as independent prescribers and who work in a hospital setting involving the care of older patients requiring acute and rehabilitative care. The experience of the nurse practitioners identified benefits to their client group through the speeding up of patient care and comfort.

3.5 Berry et al (2006) undertook a small exploratory study with potential future patients to assess the level of confidence that they would have in nurse prescribing. The focus for the study was adherence and concerns in relation to supplementary prescribing for chronic long term coronary heart disease. The study sought the views of people who had not yet been prescribed medications by nurses. Overall, the study provided support for nurse prescribing and

indicated that the participants would have confidence in the nurse's ability to prescribe the best medicine for them.

3.6 Adrian O'Dowd (2007), in describing the emerging situation following the opening of the formulary for independent prescribers, identified that there are highly positive features. There are also, however, still barriers to making full use of prescribing; these include CPD budgets, lack of medical mentors, the medical profession's resistance, and Trusts delaying the practising of prescribers due to the updating of job descriptions.

3.7 As can be seen, the issues concerning community nurse prescribing are in part replicated in the literature concerning independent and supplementary nurse prescribing (Travers, 2005; Basford, 2003; Larsen, 2004) and supports the anecdotal evidence available in Northern Ireland.

**Issues that require consideration**

3.8 The analysis of these studies, none of which was carried out in Northern Ireland, identified a number of issues relating to the ongoing introduction of nurse prescribing; these included:

- the role occupied by those who have completed prescribing programmes does not always require them to use the competence they have developed
- there can be limited support for nurse prescribing by medical colleagues
- the nurse prescribers may lack the necessary knowledge
- the nurse prescribers may lack confidence to undertake the role
- uncertainty of diagnosis
- there can be support in the role from senior managers or peers
- conflicts with medical colleagues can be an issue
- there may be a lack of infrastructure to enable nurse prescribers to practice
- the nurse prescriber's workload has increased
- there may be limited opportunities for Continuing Professional Development
- the restricted formulary can be a barrier to the development of the role.

As can be seen from the experience in Great Britain, a number of barriers were considered to impact on the successful implementation of nurse prescribing, which needed to be given due consideration in ongoing development of nurse prescribing.

# SECTION FOUR

## Nurse Prescribing Role Development

4.1 Many roles have been introduced or developed within nursing and midwifery over the years (Wanless, 2002). Read and Graves (1994) identified three main driving forces for new role implementation or change as:

- policy forces
- managerial forces
- professional forces.

4.2 The introduction of nurse prescribing would fit into all three categories (Bradley et al, 2005; Larsen, 2004). It was viewed as a role development that would enhance patient/client care by providing easier access to treatment and, as such, was actively encouraged by the policy makers. Managers concurred with this view and also saw that, in economic terms, it had the potential to save money, and in addition, may help with policy changes such as the reduction in junior doctors' hours. At a professional level, it was viewed as a development that would enhance the autonomy of the practitioner (McCartney et al, 1999). Role development was an essential component of the introduction of independent and supplementary nurse prescribing, since it represented a significant change in the way in which nurses and midwives would work.

### The NIPEC Development Framework Role Development Guide

4.3 The work undertaken by NIPEC as part of the Development Framework included a *Role Development Guide*. As part of this activity, a comprehensive review of the literature was undertaken; this is reported in *the Role Development Foundation Paper* (McGrath, 2006) and is available to download from the Development Framework website www.nipecdf.org This literature

review demonstrated that new roles were often introduced in a fragmented and unco-ordinated way that did not always provide a supportive infrastructure and could result in change that was not sustained. This was endorsed by the work commissioned by NIPEC to explore innovative nursing and midwifery roles within Northern Ireland's HPSS (McKenna et al, 2005).

4.4 The provision of a system that supported a structured approach to role development was advocated through the literature reviewed (Shewan and Reid, 1999; Humphries and Masterton, 2000; Reid et al, 2001). This resulted in the NIPEC Development Framework Project Group developing a *Role Development Guide* for the introduction of new or significantly changed roles. The guide was designed to be of benefit to practitioners and managers. A copy is attached at Appendix One.

4.5 *The Role Development Guide* comprises eight sections, intended to guide the process of developing new roles or redesigning existing ones. The various sections of the Guide address important elements of the introduction of new or significant role development.

The eight sections are as follows:

1. Assessing the Need for Role Development.
2. Planning for Role Development.
3. Type of Role Development.
4. Leadership and Management.
5. Competence Development.
6. Professional Accountability.
7. Governance Requirements.
8. Evaluation and Future Considerations.

# SECTION FIVE

## The Project

5.1 As indicated earlier, the Trust Nurses Association (TNA) asked NIPEC to review the prescribing role for nurses and midwives in Northern Ireland. There are many aspects of prescribing for nurses and midwives that could be investigated. It was decided to give consideration to the work that NIPEC could undertake in this regard through hosting a scoping workshop with TNA nominees to consider the parameters for the project. The workshop was held at NIPEC on 4th August 2006.

## The Scoping Workshop

5.2 It was proposed to workshop participants that NIPEC would review the extent to which a systematic approach to the introduction of nurse prescribing roles would have enhanced implementation in Northern Ireland. The participants reviewed the *NIPEC Development Framework Role Development Guide* to consider the extent to which it could be used as a framework to describe the barriers and enablers to implementing nurse prescribing; and to identify best practice to inform future developments. It was also hoped that some data could be collected regarding registrants who completed preparation programmes and were not currently in roles that support nurse prescribing. Those who attended the meeting approved the proposed approach and it was agreed that *the Role Development Guide* would be used as a framework for seeking information.

## The Project Plan

5.3 Further to the work undertaken at the Scoping Workshop a Project Plan was drawn up by NIPEC officers. A Steering Group was convened. The TNA nominated the Chair; Hazel Baird, Director of Nursing for Homefirst Community HSS Trust. A copy of the membership is attached at Appendix Two. The first meeting of the Steering Group was held on 10th October 2006. The remit of the group and the Project Plan were agreed at this meeting. A copy of the Terms of Reference for the Steering Group is attached at Appendix Three and the Project Plan (Version 1) is attached at Appendix Four. The project was

scheduled to complete in June 2007. It was also agreed that the work of the project would involve the gathering of a limited set of evaluative data to inform the work, and would use questionnaire distribution and a key stakeholder workshop as the key methods of data collection. The overall aim of the project was agreed as a review of the implementation of nurse prescribing in Northern Ireland to identify enablers and barriers. The Steering Group met every one to two months to oversee the work of the project and receive reports on its progress.

# SECTION SIX

## Data collection

6.1 To meet the overall aim of the project, it was agreed that the main method of data collection would involve developing questionnaires for distribution to lead prescribers[4] in HSS Trusts and to a sample of registrants who had completed prescriber programmes. To verify the findings of the questionnaire analysis a key stakeholder workshop would be held. As will be described later in this section, there was a poor return from the questionnaire distribution; the Steering Group, therefore, agreed at its January meeting that a series of focus groups would be convened to gather further data to augment the findings of the questionnaire analysis.

### Questionnaires

6.2 As indicated above, the initial methodology agreed for the project included a questionnaire for completion by lead prescribers and nurse prescribers. NIPEC, as part of its work in designing a Development Framework, published a *Role Development Guide and Role Audit Tool* designed to facilitate a systematic approach to the introduction of new roles or a significant change to a role. It was agreed by the Steering Group that the questionnaire would be based on the *New Role Audit Tool* (ref www.nipecdf.org) as a means of identifying areas for investigation and finding out about barriers and enablers to the implementation of nurse prescribing.

[4] This term has been used throughout the report to identify senior nurses occupying HPSS Trust roles that require them to co-ordinate nurse prescribing activities.

6.3 The purpose of the questionnaires was to gather information on the implementation of nurse prescribing in HPSS organisations and to identify aspects of good practice in relation to Community Practitioner Nurse Prescribers (District Nurse/Health Visitors) and Independent and Supplementary Nurse Prescribers.

6.4 The questionnaires were divided into **TEN** sections; copies are attached at Appendix Five. Each section of the questionnaire was designed to allow free comment responses for both the implementation of Community Practitioner for Nurse Prescribers (District Nurse/Health Visitor) and Independent and Supplementary Nurse Prescribers. The New Role Audit Tool comprises eight areas, which are the first eight sections of the questionnaire. The final two sections of the questionnaire requested information about examples of best practice and any suggestions for improving the implementation of nurse prescribing in an organisation.

6.5 Contact details of the person completing the questionnaire were requested to enable further clarification regarding responses, if required, and to establish the breadth of the sample of responses. It was identified that respondents details would not be published in any form as part of the project.

6.6 The draft questionnaire was presented for comment and agreement to the Nurse Prescribing Steering Group members at the first meeting on 10th October 2006. The questionnaire was agreed in principle by members, with further comments forwarded to the project lead by e-mail. A small pilot of the draft questionnaire was also conducted using lead prescribers and nurse prescribers who were members of the Steering Group. The questionnaires were amended, taking account of the comments and feedback received.

6.7 The issue and return rate from the questionnaires is identified below in Table 1. As can be seen, this return rate represented a poor return and it was difficult to draw conclusions from the data.

| Respondent | Number issued | Number returned | % returned |
|---|---|---|---|
| Lead prescribers | 19 | 10 | 52.63% |
| Health visitors | 98 | 15 | 15.3% |
| District nurses | 72 | 5 | 6.94% |
| Independent and supplementary prescribers | 78 | 14 | 17.95% |
| Nurse prescribers in total | 248 | 34 | 13.7% |

**Table 1: Questionnaire issue and return rates**

**Focus Groups**

6.8 The above table represented a significantly limited response rate to the questionnaires, and it was agreed by the Steering Group members at their meeting on 8th January 2007 that it would be difficult to draw substantive conclusions from the data available. It was decided to convene a number of focus groups with prescribing advisers, prescribing leads, community nurse prescribers and extended and supplementary nurse prescribers. All prescribing leads and prescribing advisers were invited to participate in the focus groups; prescribing leads were asked to select nurse prescribers to participate in the groups.

6.9 The focus groups met in three centres across Northern Ireland and were facilitated by Senior Professional Officers from NIPEC. The questionnaire items were used to formulate questions for the focus group attendees; copies are attached at Appendix Six. The questions were circulated to the participants in advance of the focus group meetings. Three focus group meetings were held for community nurse prescribers: 26 participants were invited, 20 attended. Two focus group meetings were held for extended and supplementary nurse prescribers: 18 participants were invited, 14 attended. Two focus group meetings were held for community prescribing advisers and lead prescribers: 23 participants were invited, 13 attended.

### Key Stakeholder Workshop

6.10 A key stakeholder workshop was held on 26th March 2007. All Directors of Nursing and Prescribing Advisers were invited to attend the workshop, together with representation from education providers. It must be acknowledged that the timing of this workshop coincided with substantive change in the HPSS, which was impacting substantially on the availability of Directors of Nursing to attend the meeting. The final workshop representation included one Director of Nursing, 11 Director of Nursing nominated representatives and two education representatives. The purpose of the workshop was to verify the findings of the outcomes of the data collection derived through the questionnaire and focus groups and analysis, and to begin to identify recommendations arising.

# SECTION SEVEN

## Data Collection and Analysis

7.1 As indicated earlier, the data collection included: issuing a questionnaire to lead prescribers and a sample of nurse/midwife prescribers; conducting focus groups with lead prescribers and a sample of nurse/midwife prescribers; and hosting a key stakeholder workshop. The questionnaires and focus group activities enabled data to be gathered regarding the implementation of nurse prescribing, using the NIPEC Development Framework *Role Development Guide* as a tool for identifying areas for investigation. The data was collected using open-ended questions to facilitate the respondents in providing information that was free from direction. The key stakeholder workshop was held to verify the findings from the questionnaire and focus group analysis and to identify any additional areas for comment.

7.2 The information from each questionnaire was typed up in full and entered on a word document under each question, using a table format with code to enable the type of respondent to be identified, i.e. community nurse prescriber, independent and supplementary nurse prescriber or lead prescriber. The data was reviewed by the project lead (Senior Professional Officer, NIPEC) and initial findings were summarised within each question area. The summary of

the questionnaire responses was verified by a second Senior Professional Officer from NIPEC. This initial report was presented to the Steering Group

7.3 The focus group discussion was recorded by the facilitator for each group (Senior Professional Officers, NIPEC) under each question heading and typed up within one week of the focus group meeting. As with the questionnaires the data was reviewed by the project lead and initial findings summarised within each question area. The summary of the discussions from the focus groups was verified by a second Senior Professional Officer from NIPEC. The summary data from the questionnaires and focus groups were combined in a single initial report under each question area. This report was presented to the Steering Group.

7.4 The summary questionnaire and focus group report was forwarded to all members who were to attend the key stakeholder workshop for review in advance of the workshop. The report formed the basis for discussion with key stakeholders, the main purpose of which was to verify the findings from earlier data. The stakeholder workshop discussion was recorded by the facilitator (project lead) and typed up within one week. A final summary report was drafted to include the findings from the questionnaire, focus group and stakeholder workshop analysis. This was presented to the Steering Group for discussion at the meeting held on 30th March 2007.

7.5 The data analysis was reviewed further by the project lead to identify key findings. The initial findings, as indicated above, were collated within each question area included in the questionnaires. The collated findings were further analysed to identify key themes. The main findings from the data analysis are presented in the next section.

# SECTION EIGHT

## Main findings

8.1 The data analysis revealed a number of key themes, which address a range of issues related to the initial introduction and ongoing implementation of nurse prescribing. It could also be argued that these have resonance with the

introduction of any role changes for nurses and midwives, both for organisations and for individual practitioners who are taking up a role that is new to an organisation, or whose role is changing substantively. The key themes that emerged included:

- the process of planning for role development
- the nature of the role
- support for the role development
- effectiveness of the role development
- enablers and barriers to the role development.

**Planning for role development**

8.2 One of the main areas for investigation in the project was the extent to which processes were used to plan for the introduction of nurse prescribing as a role that involves a substantive change for nurses and midwives. The NIPEC *Development Framework Role Development Guide* has within it a number of areas that address planning processes, both at an organisational level and at an individual level for the practitioner whose role is new or changing. The areas addressed within this key theme include: assessing the need for the role; impact on other professional roles; work undertaken to plan for the role; development of a communication strategy; and, time frame for implementation of the role.

8.3 It was identified that planning for the role development was not a strong feature when nurse prescribing was introduced. This was the case for community nurse prescribing and independent and supplementary nurse prescribing were introduced as a result of national developments and subsequent government directives following the setting up of legislation. The DHSSPS set up departmental groups to facilitate the implementation of nurse prescribing and, particularly in relation to the introduction of community nurse prescribing, set up roadshows to inform key stakeholders of its introduction. There was a fairly consistent view expressed that independent and supplementary nurse

prescribing was introduced hastily and there was, at its initial implementation, a lack of time to give full consideration to the planning processes.

8.4 Overall, the responses indicated that, at an organisational level within HPSS Trusts, there was a minimal assessment of the need for the role in relation to either type of nurse prescribing. There was, however, a general view that the introduction of the role would enhance patient and client care – this was a view that emerged across all areas investigated in the project. It was considered that the introduction of nurse prescribing was a highly desirable extension of the role of nurses and midwives.

8.5 Community nurse prescribing was viewed by the DHSSPS and HPSS Trusts as an integral part of the role of all district nurses and health visitors. It was agreed within Northern Ireland that preparation for the role would be incorporated into district nursing and health visitor education programmes. As a consequence, there is an expectation that all health visitors and community nurses will use nurse prescribing competencies within their roles. Assessment and planning for community nurse prescribing in relation to individual posts was, therefore, not identified within the data.

8.6 Independent and supplementary nurse prescribing was, however, intended to be implemented in relation to the roles that individual nurses or midwives occupied. The responses indicated that these practitioners were either identified by their managers for places on the prescribing programme or self-selected. It clearly emerged in the responses that, for the majority of the course participants in the first programme in particular, the planning to meet the need for their individual role extension was minimal or non-existent. The respondents strongly indicated that this situation has now been resolved. Selection processes have been developed that now include a detailed review of roles. Only those practitioners who occupy a role where nurse prescribing would enhance patient or client care are selected for admission to the prescribing programme.

8.7 There was minimal evidence to suggest that the resource impact of the implementation of nurse prescribing was evaluated. The consensus view of the

respondents was that no additional funding was provided for the introduction of nurse prescribing. The most common response to this area of enquiry was that the resource implications were met within the Trust budget. The independent and supplementary prescribers in a specialist role reported that whilst undertaking the preparation programme, they had to reduce their patient contacts because there were no other prescribers with their specific expertise who could replace them.

8.8 There was also limited evidence of the development of effective communication strategies within the HPSS Trusts to facilitate the introduction of nurse prescribing within the organisation. It was agreed that the DHSSPS had mechanisms in place to provide for the provision of information about nurse prescribing. Generally the HPSS Trusts did not make provision for discussion with key stakeholders within the Trusts to explore the impact of nurse prescribing within the organisation or develop the necessary infrastructure to support the introduction of nurse prescribing. One Trust did report a structured communication strategy which involved: a presentation to Trust Board; establishment of a non-medical prescribing steering group; development of policy; publishing articles in the corporate magazine; nurse prescribing as an agenda item on nursing executive team meetings; involvement of stakeholders; and, agreeing a time frame for introduction. This can be viewed as an example of best practice.

8.9 A number of responses indicated that certain difficulties were experienced with their medical colleagues, some of whom did not support nurse prescribing. Others who had agreed to mentor prescribing students did not initially appreciate the time required and withdrew their support. Some General Practitioners were also anxious regarding the possible implications for their prescribing budgets if inappropriate prescribing took place.

**Nature of the role**

8.10 The description of the nurse prescribing role, how it operates in practice and how nurses and midwives are prepared for their role, are also important in relation to the implementation of nurse prescribing in the health sector. The

areas of the *NIPEC Development Framework Role Development Guide* that address this include: links with service objectives and benefits to clients and patients; job descriptions and competencies for the role; and, preparation for role.

8.11 As indicated earlier, the data supported the concept that nurse prescribing was viewed as an important part of role development for nurses and midwives and would enhance access to treatment and medication for patients and clients, resulting in improvements in care. This was a key finding that recurred through all areas of the data and was strongly endorsed by the majority of respondents, particularly those in specialist roles. Specific developments in provision of services that had been significantly improved by the introduction of nurse prescribing were identified and included: the introduction of nurse-led services for the homeless; health care for prostitutes; and developments in palliative care.

8.12 The majority of respondents indicated that the introduction of the role enabled Trusts to meet service objectives, although they did comment that initially the introduction of nurse prescribing was not generally linked to service objectives. It was agreed that this had been strengthened and ongoing implementation was more likely to be linked with Trust targets and service developments. It was agreed, however, that this was an area that required further attention.

8.13 The NMC has set proficiencies in relation to the regulation of nurse prescribing, which form the basis for the implementation of the role. This has not, in the main, been followed up at Trust level. Community Nurse Prescribers indicated that an additional bullet point had been added to all job descriptions identifying nurse prescribing as an area of practice, whether or not their role required this. Independent and supplementary prescribers described a mixed picture, with some having well developed role specifications and Knowledge and Skills Framework (KSF) outlines with a well defined development pathway. Others, representing the majority of responses, demonstrated that there was a limited description of their role. Some also identified that competencies were

developed in accordance with patient need and in agreement with medical colleagues.

8.14 All nurse prescribers are prepared for their role through an NMC approved programme of preparation. Varying opinions were expressed regarding satisfaction with the delivery of the programmes. Community nurse prescriber responses ranged from very limited to very useful. Independent and supplementary prescribers also indicated varying levels of satisfaction, with some describing the programme as thorough and in-depth and preparing them well for the role, while others felt it was too broad, addressing topics not relevant to their specific area of practice and with too much content to cover within the timescale. The overall view expressed by managers and lead prescribers was that the programmes enabled nurse prescribers to develop the required competencies for their role. Notwithstanding this view, the data analysis also identified the community prescribing programme as requiring a more focused practice component and it was felt that certain elements, such as prescribing practice should be a compulsory element within the programme.

**Support for role development**

8.15 The provision of an organisational infrastructure to support new or substantive changes in roles for nurses and midwives was considered a key aspect of the *NIPEC Development Framework Role Development Guide*. This was seen as important to ensure support for the development at an organisational level and support for the practitioners in their new role. The areas addressed within this key theme include: support for the new role at a senior level; policy development; professional support for practitioners; ongoing appraisal of competence; and continuing professional development.

8.16 There was general agreement among the respondents that there was support at a senior level within the organisations and that the Directors of Nursing in the Trusts championed the introduction of nurse prescribing. The Health Boards had also appointed prescribing advisers, who were highly valued in relation to the support of nurse prescribing within the HSS Trusts.

8.17 There was also agreement that each Trust had an appointed lead prescriber in post, although community prescribers did not have a clear idea of who this person was and of the level of support provided to them. The independent and supplementary prescribers had more clarity in this regard. The lead prescribers themselves found the responses of the community prescribers surprising but did identify that their lead prescriber role was in addition to their main role purposes and that they had little time to dedicate to nurse prescribing. There was agreement that the lead prescriber was an important role in the ongoing developments in nurse prescribing.

8.18 There was mixed evidence of ongoing support for nurse prescribers, ranging from a high level of support to limited support. This was more strongly evidenced by community nurse prescribers. These prescribers expressed views regarding the need for line managers to provide stronger leadership for the ongoing implementation of nurse prescribing. It was considered by some that their line managers had a lack of understanding of nurse prescribing. Independent and supplementary prescribers were more positive in their views regarding support for themselves and for their role. A number of Trusts have introduced groups, such as a Trust Prescribing Forum for non-medical prescribing; this group provided support and mechanisms for the ongoing development of non-medical prescribing in the Trust. Where this was in place, it was considered by respondents to be highly beneficial.

8.19 It was also reported that a number of nurses and midwives who were prepared as prescribers were not prescribing. Reasons given for this included: a lack of support and encouragement to undertake the role; no longer in a clinical role that requires nurse prescribing; no benefit to current patient and client group; lack of time to implement the role; a lack of confidence; GPs not supporting nurse prescribing; and practical difficulties with using and accessing clinical management plans.

8.20 Professional supervision was seen to be limited across all prescribing groups, as were mechanisms to ensure ongoing competence and continuing professional development. It was considered by respondents that this should

be addressed within annual appraisal structures, the implementation of KSF and ongoing development of supervision in Northern Ireland (NIPEC 2006). It was also considered that peer support and supervision by nurse prescribers should be explored; this would also provide networking opportunities.

8.21 A range of methods was also considered to be used by Trusts to manage accountability and professional regulation. The main issue identified was the development of medicines management policies and, in some cases, policies specifically related to nurse or non-medical prescribing.

**Effectiveness of the role development**

8.22 Essential components of The NIPEC *Development Framework Role Development Guide* include ensuring that systems are in place to evaluate the effectiveness of the new role and that the implementation of the role is set within a robust governance framework. The areas addressed within this key theme include: risk assessment processes; governance arrangements; and evaluation processes.

8.23 There was no information provided in any of the responses to indicate that any level of risk assessment was undertaken in advance of nurse prescribing being implemented. This is seen as a necessary part of the introduction of new roles - to identify potential risks and establish mechanisms to minimise risk. There was evidence, however, indicating that all Trusts had varying clinical and social governance structures that included: risk management and governance processes; policy development; audit of nurse prescribing practices, including an audit of prescriptions; dissemination of information with a particular focus on legislation updates; performance review; verification of prescribing status; and, personal and Trust liability systems. The overall consensus amongst the respondents was that the governance processes were robust and managed risk appropriately. The view was expressed that a regional approach to risk assessment would be helpful.

8.24 It was evident across all responses that formal evaluation processes to assess the effectiveness of the implementation of nurse prescribing had not been developed. A small number of respondents indicated that their Trusts had

undertaken audits of nurse prescribing practices and one respondent reported that a patient satisfaction survey had been conducted. Most respondents commented on the usefulness of the NINA and drug prescribing analysis reports provided by the Central Services Agency as a means of managers and nurse prescribers receiving information about the prescribing practices of individual nurse prescribers. It was agreed that there was a need for the development of an evaluation strategy, preferably using a regional approach. It was acknowledged that the recent introduction of independent and supplementary nurse prescribing would need to be taken into account.

**Enablers and barriers**

8.25 The respondents were asked to identify enablers and barriers to the successful implementation of nurse prescribing. A large number of factors were identified, which have been collated into the following areas for consideration:

- The vision, of and support from, leaders was seen as a significant enabler. Particular mention was made of the role of the DHSSPS and Directors of Nursing in this regard.
- The support and co-operation of colleagues, including other nursing or midwifery colleagues, medical colleagues and other professionals was also viewed as a significant enabler and the lack of support or co-operation of these groups was seen to be a highly significant barrier.
- The development of a visible communication strategy was considered to be essential to ensure that all key stakeholders were informed and involved in the implementation of nurse prescribing. Limited or no involvement of such professional groups was seen to impact significantly on the successful implementation of nurse prescribing.
- Other enablers were identified that would permit different professional groups to see the benefits of implementing nurse prescribing and included: explicit links between nurse prescribing and service objectives; the description of the potential enhancements in patient or client care; and, relevance to the specific role of individual nurses and midwives.

- The development of the necessary infrastructure to support nurse prescribing in advance of its implementation was viewed as a critical enabler. There were several examples of how this had negatively impacted on the successful introduction of nurse prescribing; these included: no identified nurse prescribing budget; difficulties with access to General Practitioner records, including access and use of electronic patient records; a lack of access to medicine management software that provides safety alerts to possible drug interactions; having to use multiple prescription pads; complex clinical management planning processes; a deficit in organisational systems in Trusts to support nurse prescribing – including professional support; and a lack of opportunities for continuing professional development.

- Other barriers included: restrictive grading policies in relation to community nurse prescribing where some Trusts only permitted G grade nurses to prescribe; the limited formulary; working across GP practice boundaries; a lack of clear standards; and difficulties with access to medical mentors.

8.26 From a review of the enablers and barriers, it can be seen that careful consideration must be given to the systems and infrastructure that needs to be in place in advance of new roles or significantly changed roles being implemented. Nurse prescribing is now implemented across the Trusts in Northern Ireland. There remains, however, the potential for significant expansion of both community nurse prescribing and independent and supplementary nurse prescribing. This could provide further enhancement in the delivery of patient and client care within traditional nursing or midwifery roles, and supporting more flexible working practices of nurses and midwives. This needs to be considered in relation to major organisational developments and to the implications of role changes for individual practitioners.

# SECTION NINE

## Conclusion and recommendations

9.1 In Northern Ireland, significant role change resulted from the implementation of community nurse prescribing in 1999 for district nurses and health visitors, and independent and supplementary nurse prescribing in 2002 for nurses and midwives. Section three of this report presents a brief summary of literature that supports the need for a structured approach to the implementation of new or significantly changed roles for nurses and midwives. The data collection and analysis undertaken for this evaluation of the implementation of nurse prescribing in Northern Ireland, in the main, presents a situation where this was not evident.

9.2 The main findings indicate that planning in advance of the development of nurse prescribing was limited, as was the estalishment of the necessary infrastructure to support the implementation of nurse prescribing and to support nurse prescribers themselves. The systems in place to ensure the ongoing assessment of nurse prescribers' competence and necessary continuing professional development are also not clearly established in a number of Trusts. In addition, mechanisms to evaluate the effectiveness of the implementation of nurse prescribing have not yet been developed.

9.3 There is, however, recognition of areas of good practice and acknowledgement that robust governance systems are in place to ensure effective risk management. Since the initial introduction of nurse prescribing, a number of areas have been addressed that have improved the situation. These include:

- New legislation to extend access to the formulary for independent prescribers
- An identified budget for nurse prescribing
- Named prescription pads for nurse prescribers
- Improved selection methods for the independent and supplementary prescribing programmes.

9.4 Notwithstanding the areas that are working well and those issues that have been addressed, there are a number of recommendations arising from this evaluation that require consideration. Some of these are specific to nurse prescribing and some are for consideration by regional bodies and Trusts, as they continue to develop new roles and extend the roles of nurses and midwives to meet the imperatives of the rapidly changing health services.

**Recommendation one**

**9.5 It is recommended that the DHSSPS, service commissioners and individual Trusts work together to ensure organisational readiness for the implementation of new roles.**

The data collection supports the fact that nurse prescribing was introduced initially due to the driving forces of the Government and the DHSSPS, and that HPSS Trusts responded by adopting a structured approach to the implementation of nurse prescribing. In particular, clear implementation processes were not evident, such as a time frame that would ensure successful introduction of nurse prescribing and the development of the necessary supporting infrastructures. Consideration should be given to the use of the *Development Framework Role Development Guide* as a tool to assist a structured approach to role development.

A significant number of barriers presented themselves during the implementation of nurse prescribing. These caused difficulties to organisations and individual practitioners and prevented nurse prescribing practice achieving its full potential for patients and for service modernisation. It is necessary to ensure that such barriers are identified and action plans developed prior to the implementation of new roles, to ensure that false and real barriers do not impede success.

**Recommendation two**

**9.6 It is recommended that policy makers, service commissioners and service providers give consideration to the policies and structures that need to be in place for the introduction of new roles resulting from government drivers.**

There was ample evidence to indicate that issues such as funding, prescription management and electronic communication systems had not been supported by policy development, resulting in barriers and difficulties. It is considered that the introduction of major policy initiatives, such as nurse prescribing, require high level discussion and policy development to ensure successful implementation.

**Recommendation three**

**9.7 It is recommended that Executive Nurse Directors, in partnership with Departmental Nursing Advisory Groups and other key stakeholders, should develop a regional strategy to evaluate the effectiveness of new roles introduced through regional policy directives.**

It was evident in the data that there was no structured approach to evaluation of the effectiveness of nurse prescribing, both locally within Trusts and at a regional level. The implementation of new roles should have concurrent development of an evaluation strategy that includes short, medium and long-term activities. The strategy should include the development of mechanisms to evaluate the ongoing implementation of the new role and the overall effectiveness of the role development once the role has been fully embedded. It is essential that tools are designed to capture data from the time of introduction of the new role. It would be helpful for major policy initiatives such as nurse prescribing to use a regional approach to the development of an evaluation strategy.

Areas that could be included in the evaluation strategy are: organisational readiness; quality and relevance; ongoing competence; prescribing practices; enhancement to patient and client experience; outcomes of care, i.e. quality

and effectiveness; patient and client satisfaction. Some of the data can be gathered from the time of implementation of the role, others only when the role has become embedded in practice.

**Recommendation four**

**9.8 It is recommended that the necessary information technology support is fully explored, in advance of new roles being implemented and in collaboration with the regional ICT programme board; and that urgent action is taken to address the specific issues arising in relation to nurse prescribing.**

It was evident from the data collected that the information technology infrastructure necessary to support nurse prescribing was still not in place, three years after implementation of nurse prescribing. This included the facility to electronically update patients' drug records and to look up their drug history and allergy status prior to prescribing. Nurse prescribers do not have access to software packages to support prescribing practice such as those available to medical prescribers in primary care. These issues represent a risk to patient safety and need to be urgently addressed.

**Recommendation five**

**9.9 It is recommended to health care providers that the implementation of nurse prescribing is supported by job descriptions, KSF outlines, and annual appraisal systems that incorporate nurse prescribing competencies.**

It was evident from the data analysis that there was a need to define clearly the nurse prescribing aspect of the role for those nurses and midwives in posts that require nurse prescribing competence. In addition, appraisal processes did not always address ongoing competence for nurse prescribing. Although it is not necessary to have specific systems related to nurse prescribing, it is necessary to address accountability issues for the nurse prescriber. Peer assessment and supervision should also be explored as a means to enable prescribers to avail

of all opportunities to maintain their skills base and sharpen their critical thinking skills.

**Recommendation six**

**9.10 It is recommended that the new Health and Social Care Authority (HSCA) should ensure continuance of the current Prescribing Adviser capacity in the four Health and Social Services Boards**

It was acknowledged that each Health Board had appointed a Non-medical Prescribing Adviser and that each Trust had allocated a senior nurse as the lead prescriber, this was commended. It is considered essential that the new HSCA continues with the appointment of Prescribing Advisers to ensure the ongoing development and probity of non-medical prescribing, including nurse prescribing.

**Recommendation seven**

**9.11 It is recommended that the each new Health and Social Care Trust makes provision for nurse prescribing co-ordinator roles, with the responsibilities clearly defined in job descriptions and dedicated time provided.**

It was recognised that the nurse prescribing co-ordinators undertook their duties in addition to an already busy work schedule. The data analysis indicated that the lead prescribers did not always have the time required to ensure that governance issues were addressed and to provide the necessary support to nurse prescribers. The reconfiguration of the new HSC Trusts could be the opportunity for exploring this recommendation.

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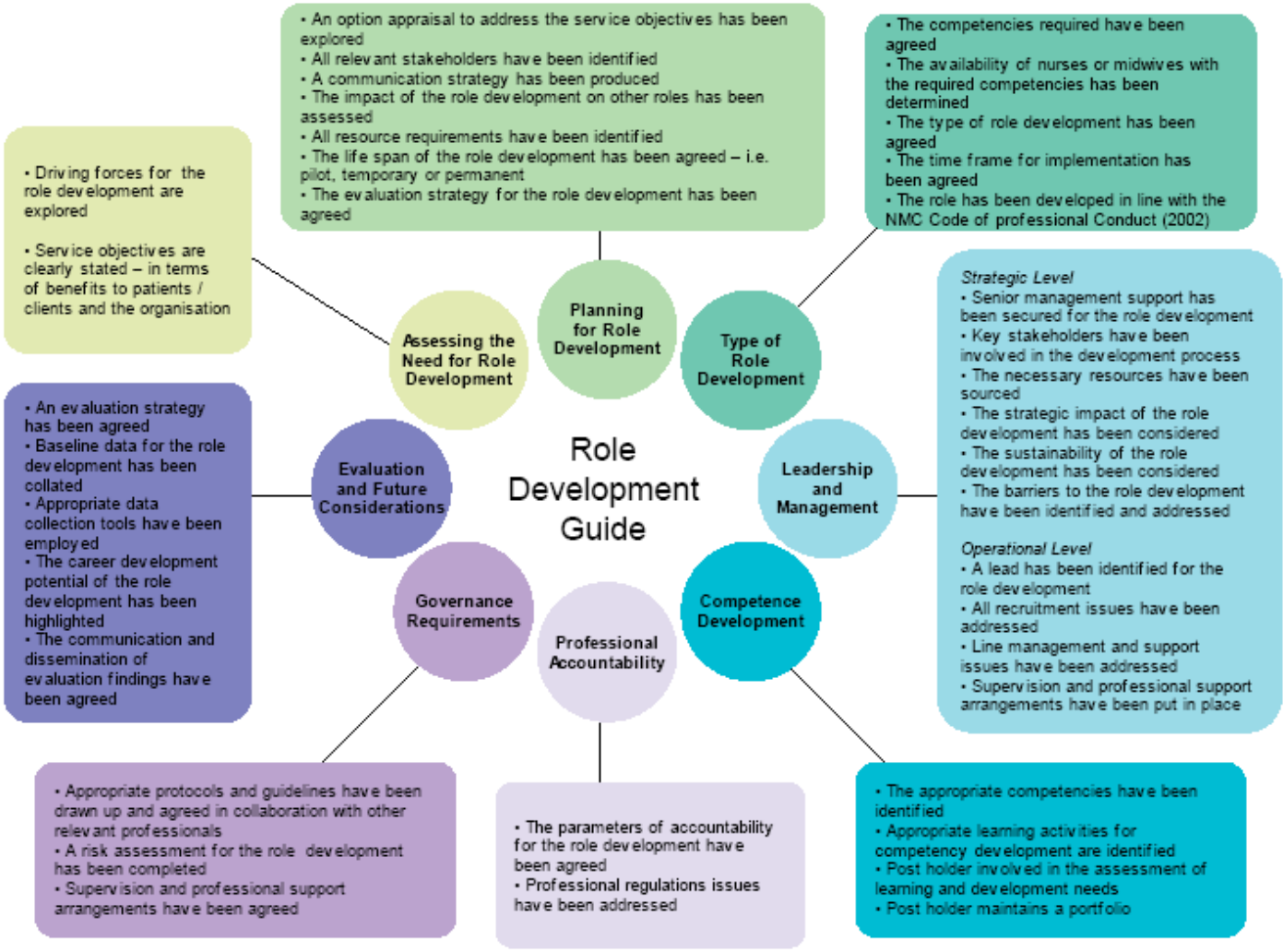
**Appendix One**



**Appendix Two**

# Steering Group Membership

| | | |
|---|---|---|
| **Trust Nurse Association Members** | | |
| Hazel Baird, Chair | Bronagh Scott | |
| **Nurse Prescribing Co-ordinators** | | |
| Eileen O'Rourke, Craigavon Area Hospital HSS Trust | Alice McQuaide, Foyle Community HSS Trust | |
| **Community Nurse Prescribers** | | |
| Andrea Gladstone, Ulster Community and Hospital HSS Trust | Allison Hume, Causeway HSS Trust | |
| **Independent and Supplementary Nurse Prescribers** | | |
| Anne Marie Marley, Mater Hospital HSS Trust | Siobhan Donaghy, Armagh & Dungannon HSS Trust | Susan Semple, North & West Community HSS Trust |
| **Prescribing Advisers** | | |
| Gillian Plant, Western Health and Social Services Board | Oriel Brown, Eastern Health and Social Services Board | |
| **Pharmacist Representative** | | |
| Terry Maguire, Pharmacist | | |
| **Education Representatives** | | |
| Marie Glackin, Queen's University, Belfast | Rosario Baxter, University of Ulster | Loretta Gribben, Beeches Management Centre |
| **DHSSPS representative** | | |
| Angela McLernon, DHSSPS | | |
| **NIPEC Representatives** | | |
| Paddie Blaney, Chief Executive | Sally Magee, Lay NIPEC Council Member | Lesley Barrowman, Senior Professional Officer - Lead Officer |
| Bob Brown, Senior Professional Officer – Deputy Lead Officer | | |

**Appendix Three**

# Trust Nurses Association Nurse Prescribing Project

# Terms of Reference for the Steering Group

## Aim

To agree aims and objectives of the project, which will review the implementation of Nurse Prescribing in Northern Ireland to identify enablers and barriers to the implementation and on-going success of nurse prescribing

## Objectives

1. To establish a project plan and methodology for the project

2. To keep the project plan under review

3. To receive progress reports and agree actions arising

4. To report the findings and make recommendations

**Appendix Four**

# Project Plan- TNA Nurse Prescribing Project

## Scope of Project

To review Nurse Prescribing ( both limited formulary (District Nurses and Health Visitors) and Independent and Supplementary Prescribing) to identify enablers and barriers to the implementation and on-going success of Nurse Prescribing and make recommendations for improving the effectiveness of Nurse Prescribing as a strategy to enhance patient care.
The Steering Group will meet on 4 occasions commencing October 2006 to oversee the work of the project (see attached work plan).

## Methodology

1. Issue a questionnaire based on the NIPECdf role development guide and outputs from the workshop held on 4th August to elicit information regarding the process of implementation of nurse prescribing. The questionnaire will be issued to the following participants (different versions for each group), which will also seek examples of best practice as a response within the questionnaire

    - Nurse Directors (or their nominees) who nominated registrants to attend Nurse Prescribing programmes of preparation as a component of the District Nurse/HV programme or Independent and Supplementary Prescribing
    - A sample of participants (20%) who completed the Nurse prescribing preparation as a component of the District Nurse/HV programme
    - All Nurse Prescribers who completed the Independent and Supplementary Nurse Prescribing Programme
    - All Nurse Prescriber leads in HPSS Trusts and all Health Board Nurse Prescribing Advisers

2. Hold a workshop to investigate the issues identified in the data analysis from the questionnaires including

    - Nurse prescribers
    - Prescribing leads
    - Prescribing advisers
    - Pharmacists

# Work plan October 2006 to May 2007

| | 2006 | |
|---|---|---|
| **Date** | **Steering Group Meetings** | **Activity** |
| 10th October 2006 | Steering group meeting 1 | Submit draft questionnaire for consideration |
| Beginning November | | Issue the questionnaire with a 3 week response time |
| Mid December | | Complete data analysis from the questionnaire |
| 8th January 2007 | Steering group meeting 2 | Report on the questionnaire data analysis |
| | **2006/2007** | |
| Late January 2007 | | Hold stakeholder workshop |
| Early February | | Complete analysis of stakeholder workshop |
| 19th February 2007 | Steering group meeting 3 | Report on stakeholder analysis workshop<br>Propose an initial set of draft recommendations for discussion |
| March | | Write draft report with recommendations |
| April to be arranged | Steering group meeting 4 | Present draft report for agreement |
| Late April | | Complete report and present to comment |
| Late May | | Submit final report |

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**June 2007**